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SECRETARY

December 19, 2007

Policy Transmittal: PSN 07-05

Re: Payment for PSN Inpatient Claims that Have Denied for Edit 503 or 669

Dear Medicaid Provider Service Network:

The purpose of this policy transmittal is to explain the process for requesting reimbursement for inpatient hospital claims that have incorrectly denied for Edit 503 or 669 due to the Florida Medicaid Management Information System (FMMIS) issue described below.

Provider Service Network (PSN) claims are intended to be exempt from the Peer Review Organization (PRO) prior authorization edits (503 and 669) because PSNs are responsible for authorizing care provided to their enrollees. However, FMMIS is applying Edit 503 and Edit 669 on inpatient hospital claims when a single hospital stay spans a Medicaid recipient's enrollment in two different PSNs. In these cases, Medicaid policy and the FMMIS require that the hospital split the bill into two claims: one for the first PSN/PCP and one for the second PSN/PCP. The claim for the first portion pays, but, currently, the claim for the second portion is incorrectly denying for either Edit 503 or 669.

Because a system fix is not possible in the current FMMIS, Florida Medicaid will pay these claims via gross adjustment until the new FMMIS under the incoming fiscal agent (EDS) is modified to accommodate such claims. To request payment of claims for the second portion of the hospital stay, the steps below must be followed:

- The hospital provider submits a clean paper claim to the PSN with documentation showing the claim denied for Edit 503 or 669.
- The PSN reviews the claim and indicates approval by affixing the standard PSN paper-claim-approval stamp to the claim form.
- As outlined in PSN Policy Transmittal 07-03: Paper Claims, the PSN submits the cover memo, paper claim, and back-up documentation to the Agency Area Office in the recipient's county of residence for initial payment processing.

Once the Area Office completes the necessary paperwork, the package will be sent to the Agency's Bureau of Medicaid Health Systems Development for approval and processing as a gross adjustment.

Payments will be listed on the PSN's and the hospital's remittance vouchers once the gross adjustments are fully adjudicated.

Such claims for dates of service between 09/01/06 and 02/28/07 must be submitted within three months of the date of this policy transmittal. For dates of service after 02/28/07, the standard Medicaid 12-month filing limit applies.



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If you have any questions or require further clarification regarding this policy transmittal, please contact your Bureau of Health Systems Development plan analyst at (850) 487-2355.

Sincerely,



Thomas W. Arnold
Deputy Secretary for Medicaid

TWA/mbv